Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VA North Florida/South Georgia HCS (VAMC Gainesville - 573 and VAMC Lake City - 573A4)

VISN 8

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 6200

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1357

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **6200** (point-in-time estimate of homeless veterans in service area) **X 35%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 62%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1357** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were not homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	637	150
Transitional Housing Beds	291	50
Permanent Housing Beds	563	100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility	Increase efforts to assist Serenity House and Volunteers of America to bring funded transitional housing beds to capacity. When these programs become available for occupancy, the result will be 36 additional beds. Our VA Healthcare for Homeless Veterans program will improve outreach to potential community partners and publicize the VA Grant and Per Diem program in an effort to generate additional proposals for transitional programs.
Long-term, permanent housing	The VA Healthcare for Homeless Veterans (HCHV) program will increase participation in local coalition meetings. A focus of this participation will be to encourage local providers to make applying for permanent housing a priority when completing the HUD Continuum of Care process. The HCHV coordinator and case managers will outreach to local housing authorities in an effort to develop new informal agreements that would facilitate increased access to permanent housing for veterans.
Dental Care	The VA Healthcare for Homeless Veterans acting coordinator will meet with new chief of dental service to discuss potential to increase ability to serve homeless veterans under existing guidelines. The Coordinator and case managers will canvas local areas to ensure that all potential resources have been identified.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 35 Non-VA staff Participants: 76% Homeless/Formerly Homeless: 11%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	1.71	6%	2.34	2
2	Long-term, permanent housing	1.74	25%	2.25	1
3	Halfway house or transitional living facility	2.03	38%	2.76	8
4	Child care	2.06	0%	2.39	3
5	Discharge upgrade	2.06	3%	2.90	15
6	Help managing money	2.12	3%	2.71	7
7	Legal assistance	2.12	0%	2.61	4
8	Job training	2.14	6%	2.88	14
9	Glasses	2.26	0%	2.67	6
10	Eye care	2.29	0%	2.65	5
11	Guardianship (financial)	2.3	0%	2.76	9
12	Education	2.31	0%	2.88	13
13	Help with transportation	2.34	0%	2.82	11
14	Help with finding a job or getting employment	2.37	9%	3.00	17
15	Family counseling	2.38	0%	2.85	12
16	Welfare payments	2.38	0%	2.97	16
17	Treatment for dual diagnosis	2.43	6%	3.01	18
18	SSI/SSD process	2.47	3%	3.02	19
19	Help getting needed documents or identification	2.57	3%	3.16	23
20	Emergency (immediate) shelter	2.66	25%	3.04	20
21	Detoxification from substances	2.71	3%	3.11	22
22	Treatment for substance abuse	2.71	16%	3.30	28
23	Drop-in center or day program	2.71	0%	2.77	10
24	Services for emotional or psychiatric problems	2.77	13%	3.20	25
25	Spiritual	2.79	0%	3.30	27
26	Personal hygiene (shower, haircut, etc.)	2.89	3%	3.21	26
27	VA disability/pension	2.94	3%	3.33	29
28	TB treatment	3.06	0%	3.45	33
29	Women's health care	3.09	0%	3.09	21
30	Food	3.11	16%	3.56	35
31	Hepatitis C testing	3.14	0%	3.41	32
32	Clothing	3.26	9%	3.40	31
33	AIDS/HIV testing/counseling	3.35	0%	3.38	30
34	Medical services	3.38	13%	3.55	34
35	Help with medication	3.38	0%	3.18	24
36	TB testing	3.41	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.17	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.86	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.69	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.77	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.82	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.76	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.42	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.18	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.58	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.37	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.92	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.22	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.85	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.69	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.85	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.11	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.07	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.73	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.77	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.81	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAH Tampa, FL - 673

VISN 8

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 5344

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1062

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **5344** (point-in-time estimate of homeless veterans in service area) **X 25%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 80%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1062** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	460	59
Transitional Housing Beds	161	409
Permanent Housing Beds	220	1000

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 18

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	VA Healthcare for Homeless Veterans program staff are negotiating with Housing Authority to not lose Section 8 vouchers as veterans are terminated. VA staff participate on coalition housing committees and Continuum of Care.
Immediate shelter	VA Healthcare for Homeless Veterans staff to continue with coalitions for additional emergency shelter grant funding.
Dental Care	VA Healthcare for Homeless Veterans coordinator will negotiate with community health care clinics for dental care for homeless veterans not in VA Grant and Per Diem Programs.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 41 Non-VA staff Participants: 63% Homeless/Formerly Homeless: 20%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	1.75	22%	2.34	2
2	Long-term, permanent housing	1.88	22%	2.25	1
3	Halfway house or transitional living facility	2.17	24%	2.76	8
4	Eye care	2.3	0%	2.65	5
5	Drop-in center or day program	2.32	7%	2.77	10
6	Emergency (immediate) shelter	2.39	34%	3.04	20
7	Glasses	2.45	0%	2.67	6
8	Personal hygiene (shower, haircut, etc.)	2.61	2%	3.21	26
9	Food	2.63	24%	3.56	35
10	Clothing	2.68	15%	3.40	31
11	Help managing money	2.9	2%	2.71	7
12	Child care	2.9	7%	2.39	3
13	Help with medication	3.02	2%	3.18	24
14	Help with transportation	3.05	7%	2.82	11
15	Legal assistance	3.2	0%	2.61	4
16	Guardianship (financial)	3.23	0%	2.76	9
17	SSI/SSD process	3.34	5%	3.02	19
18	Education	3.38	0%	2.88	13
19	Help getting needed documents or identification	3.39	2%	3.16	23
20	Detoxification from substances	3.43	2%	3.11	22
21	Welfare payments	3.44	0%	2.97	16
22	Women's health care	3.49	2%	3.09	21
23	Job training	3.55	2%	2.88	14
24	Help with finding a job or getting employment	3.55	0%	3.00	17
25	Discharge upgrade	3.56	0%	2.90	15
26	Treatment for dual diagnosis	3.61	0%	3.01	18
27	Family counseling	3.61	0%	2.85	12
28	AIDS/HIV testing/counseling	3.63	0%	3.38	30
29	VA disability/pension	3.74	7%	3.33	29
30	TB testing	3.85	0%	3.58	36
31	Spiritual	3.86	15%	3.30	27
32	TB treatment	3.88	0%	3.45	33
33	Hepatitis C testing	3.88	0%	3.41	32
34	Treatment for substance abuse	3.9	0%	3.30	28
35	Medical services	3.93	2%	3.55	34
36	Services for emotional or psychiatric problems	4	5%	3.20	25

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.71	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	2.84	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3.81	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	3.74	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.59	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.84	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.53	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.63	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.95	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1.73	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.83	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.95	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.63	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.65	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.47	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.68	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.53	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.47	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.44	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.38	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC Bay Pines - 516

VISN 8

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1500

2. Point-in-time estimate of Veterans who are Chronically Homeless: 406

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1500** (point-in-time estimate of homeless veterans in service area) **X 40%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 67%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 406** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	800	500
Transitional Housing Beds	200	250
Permanent Housing Beds	100	500

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Improve committee involvement. Participate at local, city, and county level. Give community agencies information on VA Grant and Per Diem applications and city and county grants available to meet homeless veteran needs.
Long-term, permanent housing	Closer association and development of resources allocated with HUD development programs. To maximize usage of all Section 8 vouchers under the VA Supported Housing program.
Treatment for Dual Diagnosis	Work with agencies that serve dual diagnosis clients to promote greater housing placement success.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 8 Non-VA staff Participants: 100% Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	1.5	25%	2.34	2
2	Glasses	1.75	0%	2.67	6
3	Eye care	1.86	13%	2.65	5
4	Long-term, permanent housing	2	13%	2.25	1
5	Help with transportation	2	0%	2.82	11
6	Job training	2.14	0%	2.88	14
7	Child care	2.14	0%	2.39	3
8	Emergency (immediate) shelter	2.25	50%	3.04	20
9	Family counseling	2.25	0%	2.85	12
10	Drop-in center or day program	2.25	0%	2.77	10
11	Help with finding a job or getting employment	2.29	0%	3.00	17
12	Personal hygiene (shower, haircut, etc.)	2.38	0%	3.21	26
13	Halfway house or transitional living facility	2.38	38%	2.76	8
14	Legal assistance	2.38	0%	2.61	4
15	Clothing	2.5	0%	3.40	31
16	SSI/SSD process	2.5	0%	3.02	19
17	Welfare payments	2.57	0%	2.97	16
18	Help managing money	2.63	0%	2.71	7
19	Guardianship (financial)	2.71	0%	2.76	9
20	Detoxification from substances	2.75	0%	3.11	22
21	Women's health care	2.75	0%	3.09	21
22	Education	2.83	0%	2.88	13
23	Discharge upgrade	2.86	0%	2.90	15
24	Treatment for substance abuse	2.88	13%	3.30	28
25	Services for emotional or psychiatric problems	2.88	0%	3.20	25
26	Help getting needed documents or identification	2.88	0%	3.16	23
27	VA disability/pension	3	13%	3.33	29
28	Spiritual	3	0%	3.30	27
29	Treatment for dual diagnosis	3.13	0%	3.01	18
30	Help with medication	3.13	0%	3.18	24
31	Hepatitis C testing	3.14	0%	3.41	32
32	Food	3.25	13%	3.56	35
33	AIDS/HIV testing/counseling	3.25	0%	3.38	30
34	TB treatment	3.38	0%	3.45	33
35	TB testing	3.5	13%	3.58	36
36	Medical services	3.63	13%	3.55	34

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.25	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.38	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.25	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.25	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.25	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.88	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.25	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.5	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.5	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.38	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.38	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.63	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.75	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.63	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.38	1.84

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CHALENG 2004 Survey: VAMC Miami, FL - 546

VISN 8

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 6000

2. Point-in-time estimate of Veterans who are Chronically Homeless: 1396

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **6000** (point-in-time estimate of homeless veterans in service area) **X 27%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 86%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 1396** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	2120	1100
Transitional Housing Beds	1862	1000
Permanent Housing Beds	1700	2100

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 2

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Ongoing funding for these projects remains a primary focus.
Immediate shelter	The most crucial need for immediate shelter remains in Monroe County, Florida. Southernmost Homeless Assistance League is lead agency for HUD Continuum of Care planning in that county. We do not have an VA Healthcare for Homeless Veterans outreach worker there; will attempt to hire LCSW for that area, have that person attend the SHAL meetings to represent veterans.
Transitional living facility	VA continues to represent veterans in the HUD Continuum of Care meetings in various counties. We provide input when identifying priorities for funding; identifying gaps/needs.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 50 Non-VA staff Participants: 58% Homeless/Formerly Homeless: 20%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Dental care	1.82	30%	2.34	2
2	Long-term, permanent housing	1.94	36%	2.25	1
3	Child care	2.12	7%	2.39	3
4	Glasses	2.37	2%	2.67	6
5	Legal assistance	2.41	0%	2.61	4
6	Guardianship (financial)	2.44	0%	2.76	9
7	Eye care	2.47	5%	2.65	5
8	Help managing money	2.48	2%	2.71	7
9	Discharge upgrade	2.63	0%	2.90	15
10	Welfare payments	2.64	2%	2.97	16
11	Education	2.71	2%	2.88	13
12	Help with transportation	2.73	5%	2.82	11
13	Job training	2.74	12%	2.88	14
14	Emergency (immediate) shelter	2.77	28%	3.04	20
15	Women's health care	2.77	0%	3.09	21
16	Family counseling	2.83	2%	2.85	12
17	Halfway house or transitional living facility	2.88	12%	2.76	8
18	SSI/SSD process	2.89	0%	3.02	19
19	Detoxification from substances	3.02	5%	3.11	22
20	Help getting needed documents or identification	3.02	0%	3.16	23
21	Spiritual	3.02	0%	3.30	27
22	Treatment for dual diagnosis	3.04	2%	3.01	18
23	Help with finding a job or getting employment	3.04	12%	3.00	17
24	Help with medication	3.11	0%	3.18	24
25	VA disability/pension	3.11	9%	3.33	29
26	Drop-in center or day program	3.15	0%	2.77	10
27	Services for emotional or psychiatric problems	3.16	7%	3.20	25
28	Treatment for substance abuse	3.21	7%	3.30	28
29	Personal hygiene (shower, haircut, etc.)	3.28	0%	3.21	26
30	Clothing	3.38	0%	3.40	31
31	Medical services	3.41	7%	3.55	34
32	Food	3.5	5%	3.56	35
33	Hepatitis C testing	3.56	0%	3.41	32
34	TB treatment	3.63	0%	3.45	33
35	AIDS/HIV testing/counseling	3.67	0%	3.38	30
36	TB testing	3.77	0%	3.58	36

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.66	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.02	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.16	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.27	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.92	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.82	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.74	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.05	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.79	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.41	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.84	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.28	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.2	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.27	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.66	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.2	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.8	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.14	1.84

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2004 Survey: VAMC West Palm Beach, FL - 548

VISN 8

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 1625

2. Point-in-time estimate of Veterans who are Chronically Homeless: 424

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **1625** (point-in-time estimate of homeless veterans in service area) **X 30%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X 88%** (percentage of veterans served who had a mental health or substance abuse disorder) **= 424** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	10	750
Transitional Housing Beds	30	30
Permanent Housing Beds	0	25

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 1

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	<no text>
Transitional living facility	<no text>
Help with finding a job or getting employment	<no text>

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 4 Non-VA staff Participants: 25% Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Emergency (immediate) shelter	1.5	100%	3.04	20
2	Help managing money	2.25	0%	2.71	7
3	Child care	2.25	0%	2.39	3
4	Long-term, permanent housing	2.75	0%	2.25	1
5	Dental care	2.75	0%	2.34	2
6	Legal assistance	2.75	0%	2.61	4
7	Guardianship (financial)	3	0%	2.76	9
8	Job training	3	50%	2.88	14
9	Education	3	0%	2.88	13
10	Detoxification from substances	3.25	0%	3.11	22
11	Family counseling	3.25	0%	2.85	12
12	Welfare payments	3.25	0%	2.97	16
13	Help with finding a job or getting employment	3.25	0%	3.00	17
14	Discharge upgrade	3.25	0%	2.90	15
15	Halfway house or transitional living facility	3.5	50%	2.76	8
16	Treatment for substance abuse	3.5	0%	3.30	28
17	Drop-in center or day program	3.5	0%	2.77	10
18	Glasses	3.5	0%	2.67	6
19	Help getting needed documents or identification	3.5	0%	3.16	23
20	Help with transportation	3.5	0%	2.82	11
21	Personal hygiene (shower, haircut, etc.)	3.75	0%	3.21	26
22	Treatment for dual diagnosis	3.75	0%	3.01	18
23	Eye care	3.75	0%	2.65	5
24	SSI/SSD process	3.75	0%	3.02	19
25	Services for emotional or psychiatric problems	4	0%	3.20	25
26	Food	4.25	0%	3.56	35
27	Clothing	4.25	0%	3.40	31
28	Medical services	4.5	0%	3.55	34
29	TB treatment	4.5	0%	3.45	33
30	VA disability/pension	4.5	0%	3.33	29
31	Women's health care	4.75	0%	3.09	21
32	Spiritual	4.75	0%	3.30	27
33	Help with medication	5	0%	3.18	24
34	AIDS/HIV testing/counseling	5	0%	3.38	30
35	TB testing	5	0%	3.58	36
36	Hepatitis C testing	5	0%	3.41	32

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.25	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.25	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	4.25	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4.75	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	4.25	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	4.5	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.25	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	4.75	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	2.5	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.5	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.5	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.5	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.5	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.5	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.5	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2	1.84

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2004 Survey: VAMC San Juan, PR - 672

VISN 8

A. Homeless Veteran Estimates

1. Point-in-time estimate of Homeless Veterans (from the CHALENG Point of Contact Survey): 50

2. Point-in-time estimate of Veterans who are Chronically Homeless: <DATA NOT AVAILABLE>

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

This veteran chronic homeless estimate is a conservative estimate. The following formula was used to obtain this estimate*:

> **50** (point-in-time estimate of homeless veterans in service area) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who indicate being homeless for a year or more at intake) **X <DATA NOT AVAILABLE>%** (percentage of veterans served who had a mental health or substance abuse disorder) **= <DATA NOT AVAILABLE>** (facility veteran chronic homeless estimate).

*Note: point-in-time estimate of homeless veterans in service area comes from CHALENG POC survey. Percentage of veterans 'homeless 1 year or more' and 'mental health or substance abuse disorder' based on FY 2004 homeless veteran intake data provided by the VA Northeast Program Evaluation Center (NEPEC). Percentages are rounded for clarity, so the actual calculated figure may be slightly different.

Our estimate does not include individuals who were <u>not</u> homeless for a year or more, but may have had four episodes in the past three years (VA NEPEC FY 2004 data does not record this information, but the FY 2005 data will).

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	132	20
Transitional Housing Beds	391	50
Permanent Housing Beds	294	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2004: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Homeless coordinator will continue to network with community agencies to identify homeless veterans and assists with coordination of services. Homeless coordinator will try to make more formal and informal agreements to benefit this population and to find immediate emergency shelter.
Transitional living facility	Transitional living facilities will be identified and veterans will access such services.
Long-term, permanent housing	Permanent housing facilities will be identified and veterans will access them.

B. Data from the CHALENG Participant Survey

Number of Participant Surveys: 13 Non-VA staff Participants: 100%
Homeless/Formerly Homeless: 0%

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Rank	Need	Score	*% want to work on this need now	**VHA score	**VHA Rank
1	Discharge upgrade	2	0%	2.90	15
2	Child care	2.13	0%	2.39	3
3	Halfway house or transitional living facility	2.14	0%	2.76	8
4	Drop-in center or day program	2.33	0%	2.77	10
5	Guardianship (financial)	2.83	0%	2.76	9
6	Emergency (immediate) shelter	3	0%	3.04	20
7	Family counseling	3	14%	2.85	12
8	Women's health care	3	0%	3.09	21
9	Services for emotional or psychiatric problems	3.11	14%	3.20	25
10	Help managing money	3.13	14%	2.71	7
11	Job training	3.13	14%	2.88	14
12	TB treatment	3.14	0%	3.45	33
13	Help with transportation	3.22	0%	2.82	11
14	Detoxification from substances	3.33	14%	3.11	22
15	Treatment for dual diagnosis	3.38	0%	3.01	18
16	Help with finding a job or getting employment	3.38	0%	3.00	17
17	Education	3.38	0%	2.88	13
18	Legal assistance	3.38	0%	2.61	4
19	Glasses	3.44	0%	2.67	6
20	Long-term, permanent housing	3.56	14%	2.25	1
21	Dental care	3.56	0%	2.34	2
22	Eye care	3.56	0%	2.65	5
23	SSI/SSD process	3.6	0%	3.02	19
24	Help with medication	3.7	0%	3.18	24
25	Spiritual	3.7	29%	3.30	27
26	Welfare payments	3.71	0%	2.97	16
27	TB testing	3.75	0%	3.58	36
28	AIDS/HIV testing/counseling	3.89	0%	3.38	30
29	Personal hygiene (shower, haircut, etc.)	4	0%	3.21	26
30	Treatment for substance abuse	4	57%	3.30	28
31	Medical services	4	14%	3.55	34
32	Hepatitis C testing	4	0%	3.41	32
33	Help getting needed documents or identification	4	0%	3.16	23
34	Food	4.13	14%	3.56	35
35	Clothing	4.13	0%	3.40	31
36	VA disability/pension	4.14	0%	3.33	29

*** % of Participants who identified this need as one of the top three they would like to work on now. **VHA: Veterans Healthcare Administration (all 138 POC sites, n=4286).**

2. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	Site	**VHA**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3	3.60
Community Accessibility: In general, how accessible do you feel community services are to homeless veterans?	3.63	3.25
VA Commitment: Rate the VA's level of commitment to cooperating with your agency to serve homeless veterans.	3	3.91
Community Commitment: Rate your agency's level of commitment to cooperating with the VA to serve homeless veterans.	4	4.05
VA Cooperation: Rate the VA's level of cooperation with your agency in coordinating services for homeless veterans.	3.75	3.89
Community Cooperation: Rate your agency's level of cooperation with the VA in coordinating services for homeless veterans.	3.88	3.90
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.17	3.70
Community Service Coordination: Rate the ability of your agency to coordinate clinical services for homeless veterans with the VA.	3.57	3.64

3. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site**	**VHA**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.6	2.60
Co-location of Services - Services from the VA and your agency provided in one location.	1	2.24
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1	2.12
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.1	2.47
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.1	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1	1.75
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.1	1.83
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.4	2.21
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1	1.77
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.5	1.72
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.3	1.77
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.11	1.84